



**STACKS**

:::: THE ::::  
MANITOBA  
MEDICAL  
BULLETIN

October, 1932



VOL. XII.

No. 10



# Manitoba Medical Association

## EXECUTIVE

Dr. A. F. Menzies, President.....	Morden
Dr. A. J. Douglas, First Vice-President.....	Winnipeg
Dr. Geo. Clingan, Second Vice-President.....	Virden
Dr. F. W. Jackson, Honorary Secretary.....	Winnipeg
Dr. F. G. McGuinness, Honorary Treasurer.....	Winnipeg
Dr. Ross Mitchell, Retiring President.....	Winnipeg

## Members Elected at Large

Dr. C. W. Wiebe.....	Winkler (Term Expires 1933)
Dr. J. M. McEachern.....	Winnipeg (Term Expires 1933)
Dr. W. J. Elliott.....	Brandon (Term Expires 1934)
Dr. A. G. Meindl.....	Winnipeg (Term Expires 1934)
Dr. E. D. Hudson.....	Hamiota (Term Expires 1935)
Dr. J. S. McInnes.....	Winnipeg (Term Expires 1935)

## Representatives of District Societies

Central District.....	Dr. W. H. Clark
Southern District.....	Dr. E. K. Cunningham
Brandon and District.....	Dr. H. O. McDiarmid
North-Western District.....	Dr. Geo. Clingan
Winnipeg Medical.....	Dr. R. Rennie Swan
Northern District.....	Dr. G. D. Shortreed
Border Medical.....	Dr. W. O. Henry

## Representatives of C. P. & S. of Manitoba

Dr. W. H. Secord.....	Winnipeg
Dr. J. R. Davidson.....	Winnipeg
Dr. W. G. Campbell.....	Winnipeg

## Representative on C.M.A. Executive Committee

Dr. J. D. Adamson.....	Winnipeg
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# The Manitoba Medical Bulletin

Published monthly by the Manitoba Medical Association  
in the interests of organized medicine in Western Canada.

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WINNIPEG

Editor: C. W. MacCHARLES

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G. L. Adamson, R. H. Fraser, C. E. Corrigan,  
Lennox G. Bell, Moore McFetridge.

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Medical Historian: ROSS MITCHELL

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# The Annual Meeting

Minutes of the Annual Meeting of the Manitoba Medical Association, held in the Royal Alexandra Hotel, Winnipeg, on Friday, September 9th, 1932, at 12.30 p.m.

The President, Dr. Ross Mitchell, was in the chair.

Attendance at meeting — 127.

Following luncheon, the meeting was called to order by the President, and the Secretary was requested to read the minutes of the last Annual Meeting, held in Brandon, September 9th, 1931.

It was moved by Dr. A. F. Menzies, seconded by Dr. F. G. McGuinness: That these minutes, having been duly printed in the *Bulletin*, be taken as read. —Carried.

## Report of Nominating Committee.

Dr. C. A. MacKenzie, Chairman of this committee, submitted the following nominations for the election of officers for the ensuing year:—

President .....	{Dr. A. F. Menzies, Morden Dr. D. G. Ross, Selkirk
First Vice-President .....	{Dr. A. J. Douglas, Winnipeg Dr. Wm. Turnbull, Winnipeg
Second Vice-President .....	{Dr. Geo. Clingan, Virden Dr. R. P. Cromarty, Brandon
Secretary .....	Dr. F. W. Jackson, Winnipeg
Treasurer .....	{Dr. F. G. McGuinness, Winnipeg Dr. Claude McRae, Winnipeg
Winnipeg Members at Large.....	{Dr. J. S. McInnes, Winnipeg Dr. A. C. Abbott, Winnipeg
Rural Members at Large.....	{Dr. C. W. Wiebe, Winkler Dr. E. D. Hudson, Hamiota

Ballots were passed, and the scrutineers retired to check same and submit report.

## Reports of Committees.

The President then reviewed in detail the report of the Executive Committee, together with reports of the Treasurer and Standing Committees, which had been printed and distributed to all members present.

It was moved by Dr. J. S. McInnes, seconded by Dr. E. C. Barnes: That these reports be ratified and accepted. —Carried.

## Report of Joint Committee on Amalgamation of the C. P. & S. and the M.M.A.

Copy of this report had been printed and handed to all members present for their consideration. At the request of Dr. E. H. Alexander, Dr. F. W. Jackson addressed the meeting at length on the matter, and spoke very favorably of the advantages that would be derived from an amalgamation of the two bodies. He reviewed the financial status of both organizations, showing the revenue that would be forthcoming from such an amalgamation, and pointed out that, over and above the expenses of employing a full-time secretary and running the office, there should be a surplus of approximately \$2,000.00 annually.



Following Dr. Jackson's report, the President congratulated him on his very clear statement on the subject.

It was moved by Dr. H. O. McDiarmid, seconded by Dr. J. D. McQueen: That the newly elected President, First Vice-President and Secretary of the Association form a committee to work in conjunction with the committee of the College of Physicians and Surgeons to effect these changes. —Carried.

Further, it was moved by Dr. A. F. Menzies, seconded by Dr. W. H. Rennie: That, at this Annual Meeting of the Manitoba Medical Association, we go on record as favorable to the union of the College of Physicians and Surgeons and the Manitoba Medical Association, and that, since the College of Physicians and Surgeons is the senior body in the profession, and in case of union would be the parent body, this resolution be forwarded to them for their favorable consideration, and that we ask them to take action to implement same.

Vote was taken, and CARRIED, with one against.

The President then suggested that this matter be left to the incoming Executive.

#### **Report of Resolutions Committee.**

Dr. G. S. Fahrni, Chairman of this Committee, read the following resolutions to be ratified by the meeting:—

1. BE IT RESOLVED THAT this Annual Meeting of the Manitoba Medical Association recommend to the Department of Health and Public Welfare of Manitoba that in the Province of Manitoba the definition of the League of Nations of a dead birth (or stillbirth) be adopted for statistical purposes, the said definition being:—

“A dead birth is the birth of a foetus after twenty-eight weeks or six and one-half months of pregnancy, measuring at least 35 cm. (14 inches) from the crown of the head to the sole of the heel, in which pulmonary respiration does not occur.”

AND THAT a copy of this resolution be forwarded to the Honorable Minister of Health and Public Welfare in the Province of Manitoba.

It was moved by Dr. F. G. McGuinness, seconded by Dr. O. Bjornson: That the above resolution as read be approved. —Carried.

2. WHEREAS the health of the community is of prime importance,

AND WHEREAS it may be found necessary to diminish Provincial expenditures,

THEREFORE, BE IT RESOLVED THAT the Manitoba Medical Association, in conference assembled, respectfully urge that the least possible curtailment of public health activities be exercised.

It was moved by Dr. G. W. Fletcher, seconded by Dr. W. J. Elliott: That the above resolution as read be approved. —Carried.

3. THAT this Association express its appreciation of the following:—

The visiting speakers: Drs. W. E. Gallie, W. B. Hendry, F. R. Miller, Geo. C. Hale, Harvey Agnew, H. E. Michelson, W. A. Fansler and T. C. Routley, who, by their presence and personal contributions, have added so much to the success of the meeting;

Dr. Ross Mitchell, Mrs. Ross Mitchell and Mrs. E. W. Montgomery, who, through their hospitality, have been of great assistance;

The Royal Alexandra Hotel, the Niakwa Golf Club and the Press of the City, who have been most liberal in assisting the Association.

It was moved by Dr. G. S. Fahrni, seconded by Dr. A. F. Menzies: That the above resolution as read be approved. —Carried Unanimously.

### Report of Scrutineers.

Dr. R. R. Swan reported that the following were elected officers of the Association for the ensuing year:—

President .....	Dr. A. F. Menzies, Morden
First Vice-President .....	Dr. A. J. Douglas, Winnipeg
Second Vice-President .....	Dr. Geo. Clingan, Virden
Secretary .....	Dr. F. W. Jackson, Winnipeg
Treasurer .....	Dr. F. G. McGuinness, Winnipeg
Winnipeg Member at Large.....	Dr. J. S. McInnes, Winnipeg
Rural Members at Large.....	{Dr. E. D. Hudson, Hamiota {Dr. C. W. Wiebe, Winkler

Dr. C. W. Wiebe was elected to fill the term of Dr. A. F. Menzies, which expires in 1933.

### Address by Dr. T. C. Routley.

Dr. Routley, General Secretary of the Canadian Medical Association, addressed the meeting and gave a very interesting account of his visit to the Centenary Meeting of the British Medical Association in London, England, and brought kind regards from our overseas confrères, particularly from Dr. Alfred Cox, past Secretary of the British Medical Association.

Dr. Routley also reviewed the financial status of the Canadian Medical Association, advising that the amount received in gift funds, which equalled that of fees collected annually, would in all probability not be forthcoming this year, and that the Association would be obliged to meet its own liabilities.

### Presidential Address.

Dr. Ross Mitchell gave an excellent address, in which he strongly advocated the necessity for the study of a scheme of public health insurance for the Province, which he considered one of the main problems before the medical profession today.

In concluding, Dr. Mitchell extended his congratulations to the British Medical Association for the success of their Centenary Meeting, also to the Canadian Medical Association for the continuance of their post graduate work. At the close of the address, Dr. Menzies congratulated Dr. Mitchell on his very interesting discourse.

Dr. Mitchell announced that a communication had been received from Dr. W. A. Gardner, who was in England attending the Centenary Meeting of the British Medical Association, extending his greetings to the Manitoba Meeting.

Dr. Menzies expressed his appreciation of the honor conferred upon him by the Association in electing him as their President.

There being no new business, it was moved and seconded that the meeting adjourn. —Carried.

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Man as an animal has to eat to live but as an omnivorous epicure he frequently lives to eat.—*Charles H. La Wall.*

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We are a conservative race; and we all find criticism a more facile process than creation.—*Sir Berkeley Moynihan.*



# Presidential Address --- M.M.A.

ROSS MITCHELL

MAY I again, this time at the expiration of my term of office, thank you for the very great honour you did me in electing me to the highest office in the gift of the medical profession in Manitoba, that of President of the Manitoba Medical Association. One cannot complain that the past year in the history of the association has been monotonous and unruffled. Our experiences, *firstly*, with a certain municipality; *secondly*, with the special committee of the Legislative Assembly appointed to investigate health problems in Manitoba; *thirdly*, with the proposal to amalgamate the Manitoba Medical Association and the College of Physicians and Surgeons; *fourthly*, with our negotiations with the representatives of the Manitoba Hospital Association and the Board of Underwriters; and *fifthly*, our discussion with representatives of the Union of Manitoba Municipalities, have convinced me that the office is no sinecure. However, far from complaining, I rather glory in the experience which has shown there is scarcely any problem that cannot be solved when those concerned meet together in an atmosphere of good will. Any burdens attaching to the office have been lightened in no small degree *first* by the labours of the Secretary, whose efforts on behalf of the Association won from an opponent grudging admiration when he designated Dr. Jackson as "the oily-tongued emissary of the Medical Association," and *secondly*, by the faithful co-operation of the executive. The rural members of the executive, particularly, are deserving of praise on account of their good attendance at meetings in Winnipeg, which have been more numerous than usual.

Only a few weeks ago the British Medical Association held a most successful meeting at London to commemorate its centenary. Our Association extends its congratulations to the British Association on reaching, during its century of existence, such a position of power and influence—influence exerted not only for the good of its members but for the welfare of mankind. It is interesting for a Manitoba audience to know that this august body was presided over by Kitchie-Okemow-O-Maskikie-Okemow, a Cree chieftain so created at Winnipeg in 1930, but better known to the world at large as Lord Dawson of Penn.

We also extend our thanks to the Canadian Medical Association for assistance given to our body and for the continuance of the post graduate scheme which made possible the visit in May of two post graduate speakers and also of the speakers from the east who adorn the programme of this annual meeting. The relations between the Honourable the Minister of Health and the Manitoba Medical Association have also been most happy.

The world-wide depression has affected all classes and the medical profession has not been exempt. In addition to reduction in income medical men have suffered from changes in medical practice and have wrestled, sometimes unsuccessfully, with the problem of giving medical care to the tremendous number of unemployed and at the same time providing for their own families or dependents. The subject of medical economics, hitherto almost neglected, has seized the attention not only of doctors but of legislators, municipal councillors, social workers and women's institutes. We must do our own thinking on this subject or others will think for us and we shall be obliged to accept the result of the working of minds not always well trained or well informed. The findings of the select committee of the Manitoba Legislature appointed to consider the resolution proposed by the member for

Birtle indicate that there will be still greater changes in medical practice in the future. This committee agreed on this one general principle "*that the cost of illness should be provided for in advance of illness, and the capital cost should be so distributed that it bears equitably upon all,*" and from that principle concluded that in Greater Winnipeg and the larger towns of Manitoba some form of health insurance appeared to be the best solution, while in Manitoba rural areas the scheme of municipalization seemed feasible. In reaching this conclusion the committee came into line with the position taken by the majority of European countries and Great Britain. British Columbia is now on record as favoring Health Insurance on the lines of Workmen's Compensation. Signs are not wanting that the United States, hitherto so conservative in social legislation, are seriously considering the question of health insurance. Undoubtedly over all the civilized world there is a tendency to extend privileges of medical service to classes unable out of their own incomes to pay for such service. With farm produce in the prairie provinces shrinking within two years to a third of its former purchasing power many in this province, formerly independent, find themselves unable to pay their way. Hence come the swing of rural municipalities to the municipal doctor scheme and the tremendous increase in the members of public ward and out patients in the city hospitals. These, however, are only makeshifts and some better solution must be found; some solution which is capable of indefinite expansion and which does not tend to make paupers.

Such a solution, in my opinion, is to be found in health insurance. The principle of insurance is so well established that it need not be discussed. The *ideal* scheme would be that every wage earner should have sufficient wages to be able to put aside a part of his earnings to be applied in payment of medical services when the inevitable illness comes, and also that he should be sufficiently enlightened to do this voluntarily and continuously during his earning period. You will see that this ideal scheme rests on two assumptions which are not in accord with the actual state of things. A great majority of our population have only enough money to meet their daily needs and cannot set aside even a small portion of their income. Again very few in the very large class of small wage earners have the necessary resolution to continue saving against the coming, uncertain as to time, of a period of sickness. It is so much easier for poor human nature to gratify the immediate need than to provide for the far-off event.

Investigation has shown that 85% of persons in the United States have incomes of \$2,000.00 per annum or less. The same is probably true of Canada. Illness, unless of the most trivial nature, cripples the financial resources of this group, particularly if the bread-winner is ill. Consequently, into every scheme of health insurance the problem of sick benefits, or compensation to the invalid worker, intrudes itself and adds greatly to the complexity of the problem. The medical profession, as a profession, is not concerned with the payment of sick benefits to individuals, and, if any scheme of health insurance is to be introduced into this province, it would be well to provide that funds for the payment of medical services and for sick benefits should be kept entirely distinct. The experience of countries which operate schemes of health insurance is that the only workable plan is based on compulsory contributions. On a small scale industrial concerns can operate such a scheme for the benefit of their employees but, if health insurance is to be applied over a province or a whole nation, the government is the only body fitted to carry it out.

It must be borne in mind that the term "Health Insurance," as it is generally used, is a misnomer in two senses. It is not specially concerned



with the maintenance of health nor is it insurance in the strict sense of the word since the government supplements the amount paid in by the contributors. In practical operation health insurance is more concerned with the payment of sick benefits than with the provision of medical service, and, further, those coming under the scheme receive more than they pay into it. At the present time we in Manitoba are in a state of transition. The old care-free days before the war when every head of a family in Western Canada was independent have gone and are not likely to return. At the present time neither the federal nor provincial governments of Canada can afford to enter upon such an extensive and far-reaching scheme as health insurance. The duty of the medical profession at the present time is to do the thing that lies nearest to hand, and to study the problems of medical economics so as to be in a position to give leadership when called upon. To quote from Simons and Sinai's recent book, *The Way of Health Insurance* — "Guidance in the formation of any health programme must depend fundamentally upon the wisdom and intelligent leadership of the medical profession." If health insurance is to come in this province, and its coming seems inevitable, our medical profession, to make its voice heard, must be well organized. The experience of the British Medical Association has shown this abundantly. It would seem wise to have the doctors of Manitoba organized into one body, instead of two as it is at present, and also to have an energetic and capable paid secretary always in a position to scan the horizon, to read the signs aright, and to be able to detect the cloud no bigger than a man's hand which threatens danger to the profession.

More important even than the creation of an organization embracing the whole profession in Manitoba is the need for the development of a spirit of unity within our ranks. Such a spirit possessed the minds of the members of mediæval guilds which, in many instances, were real fraternities. Such a spirit in modern days dwelt in Osler who by example and precept taught the value of unity and friendship. "Commune freely and frankly and openly with your colleagues," he said to his fellow practitioners; "Mingle with them in societies;" "Seek their aid. Trust them in emergencies, and in the immense majority of instances they will merit your trust." Be jealous of the honour of your profession and of its professors, using the word in its old sense. Strive to do or say nothing that will traduce it or them and seek to emulate those noble souls who have made medicine illustrious among the vocations to which men apply themselves.

The action of the University in reducing the number of admissions to the Faculty of Medicine to a point where each student can receive individual attention is a wise step but it is probable that the laws of supply and demand and of economic return will operate still more strongly to reduce the number of those applying for admission to the ranks of the profession. This will probably be a good thing for the community as a whole since the best trained man is the most capable and, in the long run, the cheapest.

What of the future of our art in this province? He would be a bold man who would strive to answer that question in definite terms. There is no reason, however, to lose hope. So long on the one hand as sickness and suffering prevail on this globe, so long on the other hand as there exist men and women who are "wary and watchful all their days that their brethren's days may be long in the land," and find their chief interest in life to render "simple service, simply given, to his own kind in their common need," so long will the medical profession be absolutely necessary in the world's scheme of things. We glory, and rightly so, in the traditions of our art which, as Lord Dawson pointed out in his presidential address before the British Medical

Association, go back 5000 years to the beginning of recorded history. It is for us to study what is implied in these traditions, to live up to them according to our lights, and to pass them on unsullied to our descendants. So long as we seek after this ideal our profession will be indispensable and other things will be added unto us — a modest competence, power, prestige and influence. May I quote the fine advice given by His Royal Highness, the Prince of Wales, to the British Medical Association last month at the great meeting in Albert Hall: "Never disassociate your professional interest from the paramount interest of the public. The two are inseparable because medicine has no frontiers. Its interest and influence are world wide. As you make your service as wide as the needs of humanity you will be an example and an inspiration throughout the whole of the civilized world."

Kipling has sung:

*"If England were what England seems  
And not the country of our dreams  
But only putty, brass and paint,  
How soon we'd chuck her;—but she ain't."*

And so, if medicine were only what too often it seems, a dull round of trivial duties, an inexact science dealing with a multitude of variables, ingratitude the return for our best efforts, the honest man starving and the charlatan reaping a rich harvest, how soon and how gladly would we leave the pathway of medicine which, in our youth, we hoped would lead to fame and fortune! Yet when, after failures real or supposed cause us to pass through the Valley of Humiliation a word of gratitude from trembling lips lifts us up to the Delectable Mountains from whose summits we catch a glimpse of the Celestial City, then, indeed, we are content to plod on our way since our eyes have been opened to what true medicine is and what it means to a suffering and bewildered world.

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## Dr. Montgomery Retires

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A short time ago Hon. E. W. Montgomery retired from the Ministry of Health and Public Welfare which he had held for five years. It is no new thing for doctors to sit in Manitoba legislatures or even to hold cabinet rank, witness the names of Bird, Schultz, O'Donnell, Harrison, Cowan, Wilson, Thornton, Armstrong and many others. Dr. Montgomery, however, was the first medical man to hold the portfolio of Health and Public Welfare which in 1927 was constituted a separate department.

When a medical man attains cabinet rank and assumes the duties of his department it is very easy for him to lose touch with his former fellow practitioners. While no one would pretend that the Minister of Health invariably pleased all the doctors of Manitoba there is no doubt that he always considered their viewpoint and was willing to receive, indeed he sought, advice from organized medicine in the province. It does not follow that subsequent Ministers of Health will give equal consideration to the opinion of physicians, and Dr. Montgomery deserves the thanks of the Manitoba profession for his attitude in this matter.

Many other things stand to his credit. Due largely to his insistence on a programme of immunization of school children there was a marked reduction in the incidence of contagious diseases. In the past three years in the case of diphtheria this amounted to 50 per cent. He was keenly interested in the reduction of maternal mortality and the last two years saw such a





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measure of success attending his efforts that Manitoba's record in this respect now compares most favorably with other provinces. Another measure which was dear to him was the establishment of full-time health units which have been so successful in the province of Quebec. A strong effort to stamp out trachoma was also made.

Other developments during his term of office were the establishment of a diagnostic tuberculosis clinic at Winnipeg, the building of the sanatorium in St. Vital, the construction of modern new buildings at Brandon and Selkirk mental hospitals, and the establishment of the Cancer Relief and Research Institute. With the idea of the prevention rather than the cure of disease constantly before him the Minister of Health had an epidemiologist, with the degree of D.P.H., appointed and extended the public health nursing service initiated by the late Hon. Dr. J. W. Armstrong. Another considerable achievement was the grouping in his department of many services formerly administered by various departments of the government. Such services as Child Welfare including Mothers' Allowances, care of the insane and the incurable, and medical care in unorganized districts came within the scope of his department.

Inspired by his friend, the late Dr. Gordon Bell, Dr. Montgomery brought to the administration of his new department the same qualities of mind and heart which had raised him to leading rank in the profession. In his new duties he was fired with the zeal of a crusader; John Bunyan would have styled him Mr. Valiant-for-Truth. The criticism had been levelled at him that expenditures on public health mounted too rapidly under his administration. The French have a proverb that one cannot have an omelette without breaking some eggs. It must be remembered, too, that he took office during a period of inflation and that many, many others failed to foresee the depression which began in the fall of 1929 and made economy a present day virtue.

No matter what political views one holds one must admit that Dr. Montgomery during his term of office was Minister of Health for the province first, and a member of his political party a long way afterward. One might indeed argue that had he been a keener politician he might still be in office, but no one can deny his sincerity or unselfishness. The doctors of Manitoba should be the last to forget this. Dr. Montgomery has deserved well of this province. His works will follow him.

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# Minutes of Executive Meeting

MINUTES of a meeting of the Executive of the Manitoba Medical Association, held in the Assembly Hall of the Medical Arts Building on Tuesday, October 11th, 1932, at 6.30 p.m.

Present:—Dr. A. F. Menzies, Dr. Ross Mitchell, Dr. F. W. Jackson, Dr. F. G. McGuinness, Dr. D. C. Aikenhead, Dr. H. O. McDiarmid, Dr. G. S. Fahrni, Dr. J. M. McEachern, Dr. W. G. Campbell, Dr. R. R. Swan, Dr. Geo. Clingan, Dr. E. C. Barnes, Dr. R. F. Yule, Dr. W. J. Elliott, Dr. J. S. McInnes, Dr. A. G. Meindl, Dr. W. H. Secord, Dr. A. J. Douglas, Dr. F. A. Benner, Dr. J. R. Davidson.

Following dinner, the meeting was called to order by Dr. Barnes, Vice-President, who was acting Chairman in the absence of Dr. Mitchell. Minutes of the last Executive Meeting, held September 7th, also Minutes of the Annual Meeting, held September 9th, were read by the Secretary and approved. Dr. Barnes then turned the business of the meeting over to the incoming Executive, and Dr. Menzies assumed the chair.

Dr. Clingan then introduced Dr. Yule, of Kenton, advising that he had been appointed by the North-Western District Society as their representative on the Executive in his place.

## Re. Safety Deposit Box.

The following resolution was adopted:—

Resolved, that *any two* of the following shall have the right of access and control of the contents of the Safe (No. 654), in the vault of The Royal Trust Company, Winnipeg, Manitoba, standing in the name of this Association:

Dr. A. F. Menzies, *President*

Dr. F. G. McGuinness, *Treasurer*

Dr. F. W. Jackson, *Secretary*

Mr. J. L. Hewitt, *Associate Secretary*

## Appointments of Standing Committees.

It was duly moved and seconded in the respective cases, that the following be appointed to act on committees for the 1932-33 season:—

### LEGISLATIVE COMMITTEE:

Dr. Ross Mitchell, *Chairman*

Dr. C. R. Rice

Dr. O. S. Waugh

### RADIO COMMITTEE:

Dr. D. C. Aikenhead, *Convener* (with power to add)

### EXTRA MURAL COMMITTEE:

Dr. J. S. McInnes, *Convener* (with power to add)

### COMMITTEE on NECROLOGY and HISTORICAL MEDICINE:

It was moved by Dr. H. O. McDiarmid, seconded by Dr. R. R. Swan: That the committees on Necrology and Historical Medicine be amalgamated, and that Dr. Ross Mitchell be appointed Convener of the new committee for the 1932-33 season, with power to add; this to be known as the Committee on Necrology and Historical Medicine. —Carried.

### MATERNAL MORTALITY COMMITTEE:

Dr. F. G. McGuinness, *Convener* (with power to add)

### EDITORIAL COMMITTEE:

Dr. C. W. MacCharles, *Editor*



ADVISORY COMMITTEE to the MINISTER of HEALTH  
and PUBLIC WELFARE:

Dr. A. F. Menzies, <i>Chairman</i>	Dr. J. D. McQueen
Dr. Ross Mitchell	Dr. A. T. Mathers
Dr. G. S. Fahrni	Dr. C. W. Wiebe

REPRESENTATIVES to C.M.A. COUNCIL:

Dr. A. F. Menzies	Dr. F. A. Benner
Dr. F. W. Jackson	Dr. E. C. Barnes
Dr. H. O. McDiarmid	Dr. Geo. Clingan
Dr. G. S. Fahrni	

REPRESENTATIVES to EDITORIAL BOARD  
of C.M.A. JOURNAL:

Dr. Ross Mitchell, *Convener* (with power to add)

AUDITORS:

Dr. A. J. Swan  
Dr. D. C. Aikenhead

REPRESENTATIVE to MANITOBA SANATORIUM BOARD:

Dr. A. J. Douglas

SIGNING OFFICERS:

*Any two of the following:*

Dr. A. F. Menzies, *President*  
Dr. F. W. Jackson, *Secretary*  
Dr. F. G. McGuinness, *Treasurer*

**Report of Joint Committee on Birth Control.**

The Secretary read letter from the joint committee of this Association and the Winnipeg Medical Society, under date of September 9th, addressed to Dr. Ross Mitchell, which enclosed the following resolution:

"Resolved, that the subject of disseminating the knowledge of contraceptive methods to those who are in dire economical straits is worthy of consideration of the medical profession, but, as the passing of such knowledge to such patients, by a Physician, is expressly forbidden by law, and against certain religious orders, we are unable, as a Society, to do anything with the subject until such time as those who have initiated and sponsored the proposal have obtained legal sanction of their cause."

Following discussion, it was moved and seconded that this report be accepted. —Carried.

**Unemployment Committee of the Manitoba  
Association of Registered Nurses.**

The Secretary read letter from Dr. J. D. Adamson, under date of Sept. 22nd, enclosing interim report of the above committee. Dr. Adamson in his letter requested that someone be appointed in his place to act on this committee, also that the report be studied and if possible some publicity given same in the *Bulletin* as to the very energetic way in which the nurses were dealing with their difficulties. Considerable discussion followed as to the fees charged by nurses and conditions in some country districts where untrained nurses were employed at very small salaries and their board.

It was moved by Dr. J. S. McInnes, seconded by Dr. W. H. Elliott: That Dr. J. D. McQueen be appointed on this committee in the place of Dr. Adamson. —Carried.

**Schedule of Fees.**

The Secretary advised that the supply of printed schedules of fees for town and country practice as prepared in 1926 had become depleted, and

that several enquiries for cards had been received recently. Discussion followed as to the advisability of printing a new schedule in view of the present economic conditions, particularly in the country. It was pointed out that there were very few instances at the present time which would warrant charging fees as shown on this list. The Secretary, however, explained that this schedule was intended to guide rather than to govern practitioners in making charges, and that the pecuniary circumstances of the patient may call for a lower charge or may justify a higher one than indicated on the table.

It was moved by Dr. R. R. Swan, seconded by Dr. Ross Mitchell: That the present schedule of fees be reprinted. —Carried.

#### **Report on Annual Meeting.**

The Secretary read report on the 1932 Annual Meeting, advising that this year goes down on record as having the largest attendance yet known. Registration totalled 253, of which 236 were actually members of the Association. Total membership in the Association is 304, which means that 78% of this number attended the meeting. Expenses incurred and revenue received left a nett cost of only \$69.34.

Dr. Swan suggested that next year the Annual Meeting be held later in September, as this year it had been extremely warm and the dates set came immediately after the summer holidays, also that the Labor Day holiday was just at that time. He suggested that a better time would be when the speakers were returning from the Western Provinces, rather than on their way out. Dr. Menzies, however, pointed out that the shooting season would interfere. It was decided to thoroughly consider these suggestions when appointing the time for next year.

Dr. McInnes made the suggestion that it would be an excellent plan to have the papers given at the Annual Meeting printed and distributed among the members so that they could be referred to, and that these might be stencilled and sent out with the *Bulletin*. The Secretary was asked to get an estimated cost on doing this work and report to the next meeting. Dr. McGuinness suggested that the papers should be in the hands of the local secretary at least a week or ten days before the meeting, which is the plan followed by the British Medical Association in obtaining proceedings of their meetings. He suggested that the Secretary write to the speakers and get these papers beforehand.

#### **College of Physicians and Surgeons.**

Letter from the Registrar of the C. P. & S., under date of September 20th, was read by the Secretary, in which they requested access to the files of the Association so that details of specific instances in which it had been stated that the College had been remiss in the proper handling of any of their business might be obtained.

The Secretary explained that this question probably arose from a few words stated by him at the Annual Meeting of the Association, and advised that he had been asked to appear before the Council of the C. P. & S. and present documentary proof of the accusations made. He stated, however, that any specific instances were in the files of the Association, and as these files were their property, he did not feel that they could be produced without the authority of the Executive.

Dr. Secord stated that the statement had been made at the Annual Meeting that the College or Council or its officers had not performed the duties entrusted to them under the Medical Act, and that the Secretary had remarked that he was quite ready to show to any member of the M.M.A. documentary proof of such cases. Dr. Secord said that, as far as his knowledge

goes, the College had always worked in harmony and there need be no feeling of resentment or antagonism. He, as one of their officers, felt that they should at least be informed of such cases as referred to, as they did not know of any of these. The Council had always done their utmost to carry out their duties, and if such remarks were to be made before 125 medical men and before the press they felt they should have these instances brought before them, not only as a matter of courtesy, but also to prevent their recurring in the future. He advised that Dr. Jackson had attended a meeting of their Executive and had brought files and mentioned one or two cases, but on production of the files of the College these cases were apparently explained to Dr. Jackson's satisfaction and he was ready to admit that as much as possible had been done in these cases. At the same time it had been stated that these were not the only specific instances, but that the Secretary was not at liberty to divulge them without the permission of the Association. Dr. Secord stated that the College were only asking that these additional cases be presented, and, as their Annual Council Meeting was to be held October 12th, requested that Dr. Jackson be authorized to bring in these files to that meeting so that they might be considered, and, if possible, satisfactorily explained.

Note: No press representatives were allowed at the Annual Meeting of the Manitoba Medical Association.

It was moved by Dr. Ross Mitchell, seconded by Dr. J. R. Davidson: That the Secretary be authorized to take with him from our files to the Council Meeting of the College of Physicians and Surgeons to be held October 12th, such correspondence as he considers necessary to present these cases.

Discussion followed by Drs. McInnes, McDiarmid and Fahrni, to the effect that they did not think the Secretary should be called upon to attend this meeting alone, but that the Association should stand behind him or take the matters up themselves. Dr. Ross Mitchell stated that in a good many cases he felt the difficulty was a misunderstanding rather than anything else, and that Dr. Jackson probably did know certain things and it might work out to the advantage of both parties to have them brought up. He felt that we should have co-operation as much as possible, and that he would volunteer to go with Dr. Jackson, if necessary, to present any specific cases. Dr. Mitchell's original motion was then put before the meeting and carried, with one exception, Dr. Fahrni voting against.

Further, it was moved by Dr. R. R. Swan, seconded by Dr. A. G. Meindl: That Dr. Ross Mitchell, Dr. G. S. Fahrni and Dr. J. S. McInnes be a committee to accompany Dr. Jackson to attend the Council Meeting of the College of Physicians and Surgeons. —Carried.

Dr. Jackson then addressed the meeting and stated that he had two or three matters that he could produce: (1) The Strathelair affair, which was never dealt with in any way by the College; (2) A letter from the Workmen's Compensation Board, stating cases which had not been adequately disposed of; and (3) Reference to the application of Dr. F. K. Purdie, of Griswold, to obtain a license to operate a drug store.

Dr. Campbell, in reply to these remarks, explained the position of the College with reference to same and what had been done by them.

#### **Correspondence.**

The Secretary read letter from the Canadian Medical Association, under date of October 7th, advising that they had been instructed by the Honorary Treasurer to make no further arrangements for post graduate meetings until definite information had been received from the Sun Life Assurance Company with reference to the renewal of the grant. Dr. Routley advised that he would inform us as soon as he had word regarding this.



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The Secretary read letter from Dr. J. D. Adamson, under date of Sept. 20th, thanking the President for his very kind reference regarding his welfare at the Annual Dinner.

The Secretary read communication received from Dr. J. M. Newstone, of Reynolds, Manitoba, a point on the Greater Winnipeg Water District, under date of October 8th. Dr. Newstone complained of the duties being performed by the Red Cross Nurses when a qualified medical man is easily accessible.

It was moved by Dr. R. R. Swan, seconded by Dr. Ross Mitchell: That this was a matter to be dealt with by the College of Physicians and Surgeons, and that the letter be referred to them. —Carried.

The Secretary advised that he had been asked by the Acting Minister of Health and Public Welfare to obtain the services of an obstetrician to give two radio talks on maternal welfare of approximately ten minutes' duration some time in the month of December. This matter was left with the Secretary to arrange.

There being no further business to discuss, the meeting adjourned at 11.00 p.m.

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## Coroner's and Autopsy Fees

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### **Re. the Right of a Coroner to Charge for an Investigation and a Death Certificate, Where an Inquest is not Deemed Necessary.**

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We have been in communication with the Attorney-General's Department with reference to the above-mentioned matter, which has been brought to a head by a local physician practising in the country, who is also a Coroner. It would appear that in instances of this kind there is conflict between two Acts. The Vital Statistics Act states that, where a death occurs and there has been no physician in attendance, the District Registrar shall ask the Medical Officer of Health of the municipality in which the death occurred to sign a certificate for the same, providing there is no evidence to warrant the calling in of the Coroner. The Public Health Act specifically lays out the duties of the Health Officer, and in these there is no mention made, as part of his duties, that he shall have to sign death certificates. It is generally considered that the Public Health Act over-rules other statutes unless specific mention is made otherwise. This has been pointed out to the Accountant in the Attorney-General's Department, and he has advised us that in future he will consider paying Coroners for making out death certificates. This, we take it, will include the usual investigation fee of \$10.00 and the regular mileage charge for Coroners.

This is brought to your attention so that, if in future you have any accounts of such cases, you will transmit them to the Accountant of the Attorney-General's Department for consideration.

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### **NOTES FROM OTHER UNIVERSITIES**

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Charles F. Martin, dean of the Faculty of Medicine of McGill University, has been elected vice-president for Canada of International Committee for Mental Hygiene.

Dr. H. G. Grant has been appointed dean of the Faculty of Medicine of Dalhousie University, Halifax, to succeed Dr. John Stewart, who resigned after many years of distinguished service. He also becomes professor of public health, succeeding the late Dr. W. H. Hattie.

# Western Canada Medical History

By ROSS MITCHELL

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WITH DR. CHEADLE ON THE FRASER — 1863

*From Cheadle's "Journal"*

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TUESDAY, OCTOBER 27th.—Went to Bowling Alley with Cusheon, & he & I each licked Milton. Thence to see Mr. Raby of whom Milton bought 2 oz. gold & I £10 of specimens. Witnessed washing up of one shaft Raby claim, shift & a half. (15 hours) over \$4,000! A preserved meat tin case full.

At 6 went up to the Hospital the other side of the creek on the top of the hill. Found there Courtney, Mr. Blenkinsopp, an old H.B. Chief Trader now mining, Mr. Crocker, manager of Macdonald's bank here, Dr. Bell, and G. P. Brown, a young Irishman assisting Dr. Black, and Billy Farren, a successful miner in the Caledonia Claim, a rough boisterous Irishman who had been a sailor. Also Janet Morris a Scotchwoman, fair, fat & forty, the wife of a man who keeps a store, & who came to make the plum-pudding &c. & of course sat down & dined with us. Champagne ad-lib, & Dr. Bell rapidly became maudlin. He was a little smooth-faced man in dress coat, with large mouth & white teeth always smiling, under some obligation to the Fitz-William family under whom his father is tenant in Northamptonshire. He rose after the first glass before we had got to pudding & proposed in the most fulsome & absurd manner Milton's health & the Aristocracy of England. "Gentlemen, Dr. Black invited me here to meet a noble scion of the noblest house in England. I don't exaggerate when I say so. I can't exaggerate. I feel grateful to Dr. Black, deeply grateful for asking me here to meet the 'noble scion' of one of the noblest houses England ever produced. It is a proud day for all of us & for this creek; it is the commencement of a new era," &c &c, quite nauseous, & he continued to propose toasts. Interlude, "He's a jolly good fellow" & sentiments, all full of the "Noble Scion." Then Dr. Black overflowing with loyalty, laying his hand upon his heart and willing to die at once for his Queen & country; proposing the health to Her Majesty. Interlude "God save the Queen". My health. Interlude "He's a jolly good fellow" &c. We then adjourned to the kitchen & had more healths; songs. And then Janet presented Milton very prettily with a handsome nugget (25 dollars) for him to give his mother from her. After which in a "gushing" speech Black presented Milton with a large gold ring made on the Creek out of "never sweat" gold worth some \$50. Billy Farren then gave me a nice gold & quartz specimen, & Janet another. After all which Dr. Bell essayed several speeches but was sung down by the company in Auld Lang Syne, & after sitting half asleep for some time made a bolt for the door which he thought was next the chimney, & was led off to bed by Mr. Brown. He rolled off with a crash twice during the evening, cutting his head against the stove. The dinner was held in the Hospital ward, the only patient a poor devil with anasarca being covered up with a piece of baize hanging from the wall. We had whist & 7 up pitch, after which supper & hot grog with numerous arguments about the mining laws until two o'clock when I persuaded Milton to come home. Both quite sober.

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Thirty-Five Years Ago—Sept. 16, 1897

Dr. Thornton, of Deloraine, who had represented the council of the Manitoba Medical Association at the big meetings in Montreal, returned



from the east; Dr. Thornton stated it was the hope of Manitoba members that the 1899 convention would be secured for Winnipeg.—*Man. Free Press*.

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**Forty Years Ago—September 27, 1892**

Among prominent Manitoba doctors were Drs. Gillies, Lynch, Corbett, Jamieson, Roche, Lundy, McFadden, Husband, Thornton (Deloraine) and Macdonald (Brandon).

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**Forty-Five Years Ago—October 4, 1887**

The fifth session of the Manitoba Medical College opened, the inaugural address being delivered by Dr. R. B. Ferguson; the chair was occupied by Dr. Kerr, dean of the faculty; among those present were Drs. Good, Blanchard, Chown, McDiarmid, Higginson, Sutherland and Hutton.—*Winnipeg Free Press*.

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## Recent Accessions to the Medical Library

**Session 1931-32**

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- Addis & Oliver—The Renal Lesions in Bright's Disease. New York, Hoeber, 1931.
- Barger, G.—Ergot and Ergotism. London, Gurney & Jackson, 1931.
- Billroth, T.—Lectures on Surgical Pathology and Therapeutics. Vol 1 (New Sydenham Soc. V. 73). Tr. fr. 8th ed. London, New Sydenham Soc. 1877.
- Billroth T.—Lectures on Surgical Pathology and Therapeutics. Vol. 2 (New Sydenham Soc. V. 76). Tr. fr. 8th ed. London, New Sydenham Soc. 1878.
- Billroth, T.—Clinical Surgery . . . 1860-1876 ed. by C. T. Dent (New Sydenham Soc. V. 94). London, New Sydenham Soc. 1881.
- Curtis, A. H.—Gynecology. Philadelphia, Saunders, 1931.
- Dawson, B.—History of Medicine. London, H. K. Lewis, 1931.
- Dawson, W. R.—The Beginnings; Egypt and Assyria. Clio medico, No. 1. New York, Hoeber, 1930.
- Geschickter & Copeland—Tumors of Bone. New York, American Journal of Cancer, 1931.
- Gregory, W. K.—Our Face from Fish to Man. New York, Putnam, 1929.
- Karsner, H. T.—Pathology, 3rd ed. rev. Philadelphia, Lippincott, 1931.
- Magnus, R.—Lane Lectures on Experimental Pharmacology (Stanford University, Medical Science, V. 2, No. 3). Stanford University, 1930.
- Osborn, H. F.—From the Greeks to Darwin. The development of the evolution idea through twenty-four centuries. 2nd ed. rev. New York, Scribner's, 1929.
- Park & Williams—Pathogenic Micro-organisms, 9th ed. Philadelphia, Lea & Febiger, 1929.
- Piersol, G. A.—Normal Histology; ed. by W. H. F. Addison, 14th ed. Philadelphia, Lippincott, 1929.
- Sherman, H. C.—The Vitamins (American Chemical Soc. Monograph. Ser.), 2nd ed. New York, Chem. Cat. Co. 1931.
- Straub, W.—Lane Lectures on Pharmacology (Stanford University, Med. Science, V. 3, No. 1). Stanford University.
- Turner & Reynolds—Intracranial Pyogenic Diseases. Edinburgh. Oliver & Boyd, 1931.
- Webel, A.—A German-English Technical and Scientific Dictionary. New York, Dutton & Co., 1930.

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### NEW SUBSCRIPTIONS TO PERIODICALS

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- French Medical Review (Published in English)—Vol. 1 & 2 (Paris). New York, French Medical Review, 1931.
- Stain Technology—Published by Commission on Standardization of Biological Stains. Ed. and Business Mgr. H. J. Conn. Quarterly Series, Geneva, New York.

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Scarlet Fever Toxin★  
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Anti-Meningococcus Serum★  
Anti-Pneumococcus Serum (*Type 1*)  
Anti-Anthrax Serum  
Normal Horse Serum

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Smallpox Vaccine★  
Typhoid Vaccine★  
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# *News Items*

— of —

## Department of Health and Public Welfare

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### **Expenditures.**

During the recent Provincial election one heard a great deal of criticism about the expenditures of the Department of Health and Public Welfare, and in talking to the men throughout the Province one is surprised to learn that it seems to be taken for granted that the total appropriation for the Department of Health and Public Welfare, which runs in the neighborhood of two million dollars, is spent for Public Health work.

It is interesting to analyse the expenditures made by the Department and actually find out how little is really spent on Public Health activities, as such. Taking the estimates for the fiscal year 1932-33, we find that the total allotment for the Department of Health and Public Welfare is \$1,979,000. Taking this amount item by item we find that the administrative offices, which include the Minister, Deputy Minister, Accountant and necessary office staff accounts for a little less than \$15,000.

The Child Welfare Division, which no one can say has anything to do with Health, accounts for over half a million dollars; and to be exact, about \$506,000.00.

The Welfare Supervision Board, which advises the Department in reference to all types of welfare work and charitable institutions, expends two thousand (\$2,000.00) dollars.

There is a division known as the Administrator of the Estates of Insane Persons, Fiscal Supervisor of Public Institutions, and Relief; and this division is responsible for the grants to public institutions, hospital aid, relief in unorganized territory, maintenance of aged persons and hospitalization in unorganized territory. We find that this division spends, exclusive of hospitalization, \$168,000.00. There is spent on Hospital grants and hospitalization \$385,000.00.

The mental institutions, as a group, account for \$720,000.00.

Altogether, these above items account for \$1,796,000.00 of the money appropriated for this year. This leaves in the neighborhood of \$190,000.00 for the expenditure of the Board of Health. What do we get for this money?

*First:* We have the Vital Statistics Division, which is responsible for the collection and tabulation of all the statistics in Manitoba in reference to births, marriages and deaths. They also supply marriage certificates, birth certificates, etc., to the public for a small nominal fee.

*Second:* We have the total cost of the Provincial Laboratory also included in this figure of \$190,000.00. This is a very economical service, however, and only costs the Department in the neighborhood of \$16,000.00 a year.

*Third:* We have the free distribution of biological products, which will amount to close of \$20,000.00.

*Fourth:* We have the venereal disease prevention programme, which requires the employment of two social service nurses and the part-time employment of two physicians, and a payment to the hospitals for cases of syphilis treated, as well as supplying the required drugs for the treatment of this disease. The expenditure of this division will be in the neighborhood of \$14,000.00.



*Fifth:* There is also employed a Chief Sanitary Inspector, and a District Sanitary Inspector for Northern Manitoba; a Director of Food Control, who is responsible for milk supplies, pasteurization plants and industries preparing food for sale. This particularly refers to the slaughtering and preparation of meats.

*Sixth:* We have had up until the present time a part-time medical man in charge of Trachoma control, and there is now employed an Epidemiologist, who is on call to assist any local Health Officer for the control of epidemic diseases.

*Seventh:* Besides all the above activities coming under the Board of Health, there is the Public Health Nursing Service, which employs in the neighborhood of fifty nurses, who are placed in districts covering the whole of the Province. This latter service probably costs us the most money, but when one dissects this service it is found that the average cost for each nurse is very moderate indeed. The nurses' salaries range from less than one hundred (\$100.00) dollars to one hundred and twenty (\$120.00) dollars per month at the present time, and the travelling expenses for each nurse are not allowed to exceed \$30.00 per month.

Actually the expenditures which might be definitely allotted to the preservation of Public Health amount to ten per cent., or less, of the total budget; the other ninety per cent. being used for, what might be classified, "uncontrollable expenditures." Any drastic saving to be made in the departmental expenditures can only be done by one or two methods.

The first of these is cutting out entirely some services. It is readily agreed that we cannot cut out grants to hospitals, and we cannot close one of the mental institutions, or discontinue relief in unorganized territory to people who are actually in want. In passing, one might say that part of this relief is medical relief in that the Department pays the medical man for any work he does for people who are actually on relief in unorganized territory, providing authority is obtained from the Department to proceed with the work. If the whole actual expenditure for Public Health Activities is wiped out, it would not mean a greater saving than ten per cent. of our total budget. This would seem to be the most foolish policy, as there is no doubt that it would immediately increase the hospital load we have to carry, also the load in reference to our mental institutions, and the load in respect to destitution in unorganized territory.

Considerable saving is being made, however, by cutting down on expenditures wherever possible without curtailing the services being rendered to any great extent, and possibly there will be an approximate ten per cent. saving in this manner of the money allotted to this Department.

The second method, and the one which is probably the most logical, would be to charge back to the individuals and municipalities a larger percentage of the cost of the work done. This proposal particularly refers to the care of old people, mothers' allowances, and the care of people in our mental institutions.

I think it can be taken for granted that any reflections on the activities of the Department of Health are also reflections, indirectly, on the practising medical profession and the graduate nurses; and on this account we think these two groups should make it their business to actually know what the facts are concerning the expenditures and activities of the Department of Health and Public Welfare, and it is for this reason this short summary is being printed in the *Bulletin*.

**Diphtheria.** The following is an extract taken from the *Illinois Health Messenger* which we thought would prove interesting to medical men in Manitoba:—

#### **Prevents 27,900 Cases of Diphtheria**

“When nature takes its course, about 1 in 10 children who are exposed to diphtheria gets the disease. The other 9 acquire immunity to diphtheria because of the exposure. This ratio varies considerably with age but in general holds true. Thus if nothing is done to control diphtheria 90 per cent. of the children never get the disease but are immunized at the expense of the other 10 per cent. who must have the disease to protect the race. About 1 in 3 of the 10 per cent. who get the disease fails to recover if antitoxin is not used.

“Immunization with toxoid or toxin-antitoxin is undertaken therefore, in the hope of preventing the disease in the 10 per cent. who under natural conditions must suffer an attack. If every child is given toxoid or toxin-antitoxin the immunizing process is stimulated not only in the 90 per cent. who would acquire protection against diphtheria in the natural course of events, but also in the 10 per cent. who would not.

“How far have the efforts at diphtheria prevention succeeded in saving 10 per cent. in Illinois from an attack of the disease? Records for the last five years indicate that diphtheria has been prevented in fully one-third of those who would under natural conditions have suffered from the disease.

“During the last five years 33,796 cases of diphtheria were reported in Illinois. If it is presumed that two-thirds of the cases were reported (a survey in 1930 indicated that at least two-thirds of the cases are reported) the actual number that occurred is 40,694.

“During the preceding five-year period 686,173 children were born in Illinois. These children passed through the age when diphtheria is most likely to occur during the last five years.

“Under natural conditions 68,617, or 10 per cent. of those children would have had diphtheria if exposed. A five-year period is sufficient to permit general opportunity of exposure in these days of rapid transportation. There were, however, only 33,796 cases reported with an estimated maximum of 40,694 cases. This indicates the prevention of fully 27,923 cases. Under modern conditions about 7 out of each 100 cases of diphtheria fail to recover. Thus it appears that the prevention of 27,923 cases saved the lives of more than 1,800 children.

“Experience with scarlet fever adds further evidence to the deductions concerning diphtheria. The attack rate of scarlet fever under natural conditions is somewhat higher than that of diphtheria. Furthermore, no preventive effort in the way of artificial immunization has been used in Illinois to a significant degree in relation to scarlet fever. During the last five years 75,570 cases of scarlet fever were reported in Illinois. Presuming that only two-thirds of the cases were reported it appears that 113,355 cases actually occurred. This would indicate an attack rate of about 17 per cent.

“Detailed history records of 13,000 students among those matriculating at the University of Illinois during the five years prior to 1927 show that 16 per cent. of the men and 19 per cent. of the women had had scarlet fever and 8 per cent. of the men and 9½ per cent. of the women had had diphtheria. Among 2,304 school children in various parts of the United States, whose ages ranged from 15 to 18 and whose health histories were taken by federal health officials, 11½ per cent. had had diphtheria. Among 1,000 white men

engaged in industrial labor at Cincinnati 7.2 per cent. gave a history of diphtheria.

"These data indicate quite clearly that the extensive use of toxin-anti-toxin and toxoid in Illinois may be credited with the prevention of at least 27,900 cases of diphtheria during the last five years. This preventive work in turn resulted in saving the lives of more than 1,800 children."

\* \* \* \* \*

### **Impetigo Contagiosa:**

There are many funny things happening in school; one, unusually so, started the smile that became the grin that cracked the "cold sore" that little Willie Jones had at the angle of his mouth. Forth from this small split oozed a yellow serum which soon dried and became a yellow crust.

Willie's fingers were never too busy at other things to neglect picking off this little crust several times a day as it renewed itself. After each picking the new crust formed was just a little larger than the previous one and within a few days other sores appeared on Willie's face and on his hands and many of his schoolmates bloomed forth with similar sores. Willie's "cold sore" was not what it seemed; it was impetigo contagiosa, and, as its name implies, this form of impetigo is contagious and is no respecter of age, quality, person or sex. It can be readily transmitted, not only by personal contact but by infected articles, such as wash cloths, towels, etc. If neglected, or, as often occurs, if useless home remedies are employed, the lesions may become very extensive and last for months, the victim being a constant menace to all about him. There are many cases in schools due to failure to diagnose the initial case. Any child having a sore with a yellowish crust, and especially a crust that shows a tendency to curl up at the edges, should be regarded with suspicion and excluded from school and other public gatherings until a diagnosis has been made by a reliable physician.

Treatment should always be under the direction of a physician and usually a cure can be effected in a few days, naturally depending on the extent of the lesions.

\* \* \* \* \*

### **Scabies.**

Another old acquaintance that often invades our schools, and one that is usually associated in the public mind with filth, uncleanness and poverty, is the little itch mite, *Acarus scabiei*. The close contact of school life furnishes a ready means for its spread; one untreated case may infect any number of children, and the itch mite has no respect for social status.

Unlike impetigo, the lesions of scabies are most pronounced on the covered parts of the body, the axillary folds, the thighs, the abdomen and, if on the hands, they are usually between the fingers.

Where the itch mite burrows into the skin there is a small raised red lesion that itches so intensely, especially at night, that usually the top is scratched off and a brownish crust is formed. Due to the fact that having the itch is considered as it is, and as sulphur ointment is quite generally known as a cure, often no physician is consulted, with the result that a severe dermatitis sometimes follows either a too-prolonged or a too-liberal use of a strong sulphur ointment. All treatment for itch should be under the direction of a physician.

\* \* \* \* \*

### **Nothing New Under the Sun.**

Here are a dozen of the characteristics with which Sir Thomas More

(A.D. 1516) furnishes Utopia—suggested to his mind by his knowledge of London as it was and his interpretation of what ought to be:—

- (1) The city is soundly builded, its streets are broad, and behind all its houses lie fruitful and beautiful gardens cultivated by the occupiers; there is a public water supply, drainage and municipal cleanliness;
- (2) Slaughtering of animals for food must be conducted in public abattoirs provided outside of town;
- (3) There are public hospitals for the efficient treatment of rich and poor, and isolation hospitals for cases of infectious disease, both outside the town;
- (4) There are communal meals, with fruit, dessert, music and lectures;
- (5) Maternity is especially cared for, and there are municipal nurses for infant welfare;
- (6) Nursery schools (or creches) exist for children under five;
- (7) Free universal education for all children, with continuation, adolescent and adult schools;
- (8) All education by the State is to include Natural Religion built on Nature and Reason;
- (9) Education is to be directed to the attainment of physical and mental health;
- (10) Vigorous and lively health is dependent on obedience to the laws of Hygiene, undisturbed and vigorous constitution of body, a temperate course of life, cleanliness, living in the fresh air and sunlight, with abundant and active occupation, but not too prolonged;
- (11) Enlightened marriage laws and marital selection;
- (12) Industrial welfare.

“They entertain themselves with the delights let in at their eyes, their ears and their nostrils as the pleasant relishes and seasonings of life, which Nature seems to have marked out for man, since no other animal contemplates the figure and beauty of the universe. - - - The people are industrious, apt to learn, as well as cheerful and pleasant, and none can endure more labor, when it is necessary.”—*Sir George Newman, K.C.B., M.D., Halley Stewart Lecture, 1930.*

\* \* \* \* \*

### COMMUNICABLE DISEASES REPORTED

Urban and Rural - September, 1932

Occurring in the Municipalities of:—

**Tuberculosis:** Total 177—Indians 62. Winnipeg 13, unorganized territory 11, St. Boniface 9, St. Laurent 6, Selkirk 4, St. Anne 4, Springfield 3, Assiniboia 2, Cartier 2, Grey 2, Hanover 2, Kildonan East 2, Kildonan West 2, McDonald 2, Montcalm 2, Portage Rural 2, Stuartburn 2, St. James 2, St. Rose Village 2, Winnipegosis 2, Armstrong 1, Bifrost 1, Brooklands 1, Carberry 1, Carman 1, Coldwell 1, Cypress North 1, Dauphin Rural 1, Dauphin Town 1, DeSalaberry 1, Elkhorn 1, Eriksdale 1, Gilbert Plains Rural 1, Gimli Town 1, Hamiota 1, Lawrence 1, Lorne 1, Minnedosa 1, Morden Town 1, Morris Town 1, Mossey River 1, South Norfolk 1, Pilot Mound Village 1, Piney 1, Portage City 1, Rockwood 1, Rosssburn Rural 1, Shellmouth 1, Siglunes 1, Swan River Town 1, St. Andrews 1, St. Clements 1, The Pas 1, Transcona 1, Turtle Mountain 1, Westbourne 1, Whitemouth 1, Winkler 1, Woodlea 1.



**Whooping Cough:** Total 104—Winnipeg 43, St. Boniface 15, North Cypress 9, Kildonan West 9, Minitonas 9, St. Anne 5, Charleswood 4, Kildonan East 3, St. James 3. Indians 2. Elton 1, Lansdowne 1.

**Scarlet Fever:** Total 64—Winnipeg 19, St. Boniface 9, Fort Garry 8, Wallace 6, Rhineland 3, St. Paul West 3, unorganized 3, Portage Rural 2, St. Vital 2, Bifrost 1, Brooklands 1, Coldwell 1, Kildonan East 1, Neepawa 1, Sifton 1, St. James 1, St. Laurent 1, Woodworth 1.

**Diphtheria:** Total 39—Winnipeg 16, Lawrence 12, Brenda 1, Charleswood 1; Dauphin Rural 1, Hanover 1, Ritchot 1, Selkirk 1, Siglunes 1, St. Boniface 1, St. Rose 1, St. Vital 1, unorganized territory 1.

**Trachoma:** Total 26—Hanover 14, DeSalaberry 4, Sifton 3, Whitehead 3, Ritchot 2.

**Typhoid Fever:** Total 25—Rhineland 6, Dufferin 3, Oak Lake 3, St. James 2, Hanover 2, Cartier 1, Elton 1, Rosedale 1, Russell 1, Silver Creek 1, St. Paul East 1, St. Clements 1, Winchester 1, Winnipeg 1.

**Chickenpox:** Total 18—Oak Lake 5, St. James 5, Rockwood 3, Winnipeg 3, Kildonan East 1, St. Boniface 1.

**Measles:** Total 16—Winnipeg 12, St. Andrews 2, Fort Garry 1, Rhineland 1.

**Cerebrospinal Meningitis:** Total 9—Winnipeg 4. Indians 3. Bifrost 1, unorganized 1.

**Mumps:** Total 4—Winnipeg 2, Dauphin Rural 1, Virden 1.

**Anterior Poliomyelitis:** Total 3—Winnipeg 1, Argyle 1, Emerson 1.

**Erysipelas:** Total 3—Winnipeg 3.

**Puerperal Fever:** Total 3—Winnipeg 2. Indians 1.

**Para-Typhoid:** Total 2:—Grey 1, St. Boniface 1.

**Influenza:** Total 1—Winnipeg 1.

**German Measles:** Total 1—Brandon 1.

\* \* \* \* \*

### COMMUNICABLE DISEASES REPORTED

During the Month of September, 1932, and Occurring During  
the Months of June, July and August, 1932,

in the Municipalities of:

**Measles:** Total 21—Rockwood 18, Minnedosa 3.

**Whooping Cough:** Total 21—Wawanessa Town 9, North Norfolk 5, Brandon 3, Oakland 2, Miniota 1, Portage City 1.

**Chickenpox:** Total 7—Blanchard 3, Minnedosa 2, Rosedale 1, St. Laurent 1.

**Mumps:**—Total 5—Rosedale 3, Odanah 2.

**German Measles:** Total 5—Gimli 5.

**Typhoid Fever:** Total 4—Cartier 2, Birtle 1, Oak Lake 1.

**Scarlet Fever:** Total 1—Unorganized territory 1.

\* \* \* \* \*

### DEATHS FROM ALL CAUSES IN MANITOBA

for Months of July and August, 1932

URBAN—Cancer 63, Congenital 29, Tuberculosis 18, Pneumonia 7, Puerperal 5, Lethargic Encephalitis 3, Diphtheria 2, Poliomyelitis 1, Cerebrospinal Meningitis 1, Typhoid Fever 1, Whooping Cough 1, Stillbirths 36. All other causes 244. TOTAL 411.

RURAL—Congenital 70, Cancer 49, Tuberculosis 24, Pneumonia (all forms) 8, Puerperal 5, Cerebrospinal Meningitis 2, Diphtheria 2, Typhoid Fever 2, Influenza 1, Stillbirths 25. All other causes 233. TOTAL 421.

INDIANS—Tuberculosis 16, Congenital 8, Puerperal 2, Pneumonia 1, Cancer 1. All other causes 2. TOTAL 30.

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There is no one measure which can compare with the decrease of physical suffering in man, woman and child when stricken by disease or accident . . . This is the Promethean gift of the century to man.—*Osler*.

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(HALIBUT LIVER OIL)

*is now available*  
*either PLAIN or with VIOSTEROL*

PARKE-DAVIS HALIVER OIL WITH VIOSTEROL-250 D was introduced to the medical profession in January of this year. This product, which is obtained from the liver of the halibut, is standardized to contain 60 times the vitamin A potency of high-grade cod-liver oil and is equal to Viosterol in vitamin D.

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Containing at least one hundred times as much vitamin A and fifteen to twenty times as much natural vitamin D as high-grade cod-liver oil.

This new product is offered in response to a demand from physicians for a preparation containing an exceptionally high concentration of vitamin A in the smallest possible bulk. When certain cases call for large quantities of vitamin A, without a correspondingly large amount of vitamin D, the demand is met in this new product, Haliver Oil (Plain).

Both Haliver Oil with Viosterol-250 D and Haliver Oil (Plain) are supplied in soft, easily swallowed 3-minim capsules. Haliver Oil with Viosterol is also available in 5-cc. and 50-cc. vials, and Haliver Oil (Plain) in 10-cc. vials.



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# Present-Day Trends of Private Practice In the United States\*

MORRIS FISHBEIN, M.D.

Consider the practitioner of medicine in 1875. His complete equipment, in most instances, consisted of his five senses developed to extraordinary degree, and such medicaments as he could carry in his saddle-bags. In the diagnosis of disease he took, first of all, a history. Since the time of Hippocrates, great practitioners have recognized the importance of a knowledge of the natural history of disease or the course that a disease usually follows. After taking a suitable history, he proceeded to confirm his diagnosis by physical observations. The temperature was estimated by placing the hand on portions of the patient that seemed to be hot. By sight the doctor tried to tell the difference between a blush and a fever. He gazed on the tongue. The eruptions associated with various exanthems were to him an open book. Even the sense of smell was employed, and many a disciple of Aesculapius gambled on his ability to diagnose diphtheria or typhoid with his nose alone. The odds in that day were far easier than at present. Then it was safe to say that one case in five was typhoid; to-day the disease has been so largely eliminated as to constitute a curiosity, viewed with amazement by medical students. The sense of touch and the sense of hearing were main reliances. Palpation, percussion, and auscultation were the three gods of physical diagnosis.

Then came the great shift from brains to glassware. Away from the bedside and into the laboratory turned the center of interest. Every secretion and excretion of the human body became the subject of weird chemical manipulations which yielded astounding information. The practitioner sat with his eye glued to the ocular of the microscope, searching for casts, counting red and white blood cells, studying mitoses, and delighting in strange crystalline conformations.

Next came the roentgen ray, and the unseen was made visible. The old time practitioner might hear the râles; the modern practitioner sees the cause of the râles. Not only were the X-rays in themselves to constitute a valuable source of exact knowledge, but soon advances in technic enhanced their usefulness. The Graham test enables visualization of the gall-bladder; the use of iopax permits gross changes in the kidney to become apparent; by the injection of air, the brain, the spinal cord, and the contents of the abdomen are outlined with the X-rays.

Before the coming of the modern era, the physician had no way of knowing exactly the ability of organs to function. When it began to be realized that the body is a great physical-chemical mechanism in which reactions constantly go on, means were developed for measuring these reactions and thereby for determining functional efficiency. Moreover, actions involving motion within the body are translated into scrolls visible to the naked eye. Thus medicine has by application of inventions in mechanics and electricity progressed more and more into a science. The microscope, the stethoscope, the ophthalmoscope, and all the other scopes associated with various organs project the human eye into dark and impenetrable cavities. The sphygmo-

\*Read before the joint meeting of the Section on Practice of Medicine and the Section on Preventive Medicine and Public Health at the Eighty-Third Annual Session of the American Medical Association, New Orleans, May 12, 1932.

graph, plethysmograph, and electrocardiograph bring the heart beat on a screen, determine the nature of its action, and indicate means for restoration of disordered function. Not all of these great contributions to the science of medicine have come from the clinic. The minute physiologic investigations on the frog, the ameba, the dog, and the cat have been translated into procedures applied to human beings for the prevention, the diagnosis, and the treatment of disease.

### **The Rise of Specialization**

Thus the five physical senses of the old-time practitioner have been prolonged, projected, and intensified thousands if not millions of times. But common sense has been little changed—and may have decreased. Knowledge has accumulated so vastly that no longer is it within the compass of one man to learn and to apply all the knowledge or the technical procedures that are available. The physician of an earlier day has evolved into the multiple specialists of the present. The specialties themselves have been divided and subdivided into technicalities beyond the comprehension of the man in the street. For example, the first of the divisions was the removal of diseases of the eye, ear, nose, and throat into a specialty. Shortly thereafter, ophthalmology and otorhinolaryngology became separate specialties. Gradually a few otologists discontinued laryngology and rhinology and began to concern themselves solely with the ear. Moreover, some of the laryngologists began to confine themselves largely to bronchoscopy or peroral endoscopy.

Indeed, the most remarkable examples of fission have taken place in what was formerly called surgery. The first splitting that occurred resulted in general and abdominal surgery; then came gynecology. Thereafter general surgeons began to limit themselves to the head, to industrial surgery, and to intrathoracic surgery, and the ultimate result of these repeated parthenogeneses is not yet in sight.

In 1925 the American Medical Directory listed 15,000 specialists; by 1928 the number had increased to 19,000; to-day there are 160,000 physicians in the United States, and at least 40,000 are specialists. In 1915, thirty per cent. of all graduates became specialists; by 1920, fifty-one per cent. of all graduates were becoming specialists; to-day three-fourths of the young men undertaking medical education have chosen their specialties before the senior year.

### **The Growth of the Hospitals**

It became apparent, just as soon as the practice of medicine began to require great expenditures for accessories and equipment, that individual physicians could not in most instances supply themselves with all of the necessary space and apparatus to carry on the multiple activities of modern medicine. Furthermore, the earlier equipment was such that it could not be readily transported to the patient's bedside. Of course, this fact in itself was a great stimulus to American inventors. To-day the cumbersome X-ray machines, electrocardiographic devices, and basal metabolic apparatus of an earlier day have been developed into portable machines that can be carried to the patient's bedside. But in 1905 it was necessary to place the apparatus in an institution and to bring the patient to the machine. This condition helped toward the tremendous increase in the number of hospitals. From 1900 to 1930 the number of hospitals in the United States increased from over one thousand to more than seven thousand; the number of beds in these hospitals increased from 421,065 in 1900 to 950,000 in 1930. At the same time, attempts were made to overcome the cost of staying in a hospital by the development of X-ray and clinical laboratories which undertake diagnostic



procedures. By 1920 there were three thousand clinical laboratories in the United States, and by 1930 the number had increased to more than four thousand.

The hospitals first built were frequently merely places providing beds and the minimum amount of laboratory service. Gradually hospitals began to provide complete X-ray departments, clinical laboratories, and physical therapy services. By 1920 there were twenty-five hundred X-ray departments in hospitals, and by 1930 more than five thousand. To-day more than seventy-five per cent. of hospitals are properly equipped with X-ray departments and clinical laboratories.

Another significant factor during this period has been the entrance into medicine of suitable nursing service. In 1890, four hundred nurses graduated from available nurses' training schools. In 1930, twenty-thousand nurses graduated from such schools, and it is estimated that, if conditions continue with the same type of education and training that existed in the past, sixty-five thousand nurses will graduate in 1950.

The coming of the hospital into medical practice, while adding greatly to the cost of medical care, has vastly improved the quality of the care. Medical service can never be judged by price; it can only be judged by quality. Inefficient medical service is expensive at any price and leads only to further expense.

#### **The Nature of Disease**

The Commission on Medical Education just a few years ago made a survey of the nature of medical practice in a typical New England Community. It was found that ninety per cent. of disease was seen and treated by the general practitioner. Of the patients seen, fifty-five per cent. were attended in their homes, thirty-five per cent. in the physician's office, and ten per cent. in the hospital. Of the 160,000 physicians in the United States, more than 100,000 have to-day an affiliation with a hospital. Even though they may not be members of the staff, they have access to the use of the operating room, X-ray department, clinical laboratory, and hospital beds. It must be constantly borne in mind, however, that ninety per cent. of all disease seen by physicians represents the type of disease that any good general practitioner can diagnose suitably and treat suitably with the amount of equipment that he can carry in a hand-bag. It is the remaining ten per cent. of disease that gives serious concern to the sociologists, the economists, the philosophers, the philanthropists, and all of those who in recent years have participated in the discussions of the cost of medical care.

The coughs, the colds, the minor digestive disturbances, the occasional rheumatic twinges, headaches, the minor gynecologic and most obstetric procedures, come within the purview of suitable control by the general practitioner. Such cases as tumor of the brain, acute hemorrhagic pancreatitis, hypertrophy of the prostate, or Raynaud's disease may demand consultation with specialists or their technical services. Any good general practitioner ought to be able to outline suitable artificial feeding for most babies in health and in disease. A pediatrician may be required for celiac disease or pyloric stenosis. The otorhinolaryngologist may offer to the patient with a vasomotor rhinitis comfort beyond what the general practitioner may give him, the allergist may seek more successfully the cause of hypersensitivity which turns out to be a reaction to leopard's dandruff, and the psychoanalyst may extract more efficiently the psychosis underlying a cardiospasm. But the vast majority of wage earners are too busy in these modern times attempting to provide their families with the ten dollars necessary each week to feed a family of

five to develop any of these exceedingly interesting but after all quite extraordinary complaints. To the wage earner who is attempting, with his family, to subsist on \$30 a week, a pain in the epigastrium is just cramps and not allergic abdominal migraine.

### **The Quality of Medical Care**

Hardly a decade has passed since one of our great sociologists initiated the circulation of the striking statement that the rich and the poor received the best medical care, and that our great middle class is not receiving satisfactory medical service for a price that it can afford to pay. All of us will agree that good medical service is essential to human happiness and that therefore good medical service should be available to all human beings for what they can afford to pay. But good medical care differs greatly from the best medical care. In view of the advances of modern medical science, it is questionable whether or not the best medical care can ever be furnished to all the people at a price they can afford to pay. It would seem rather that we must work toward the period when all of mankind in this country will receive the best medical care that they can be furnished for what they can afford to pay. Thus, the person who seeks transportation to New York travels by bus, by day-coach, by Pullman, and in the Pullman he has a lower, an upper, a compartment, or a drawing-room, according to what he can afford to pay. He may indeed choose rather to make the trip by airplane. No economist has suggested, however, that drawing-rooms be provided for all who care to make the trip at a fixed price. Indeed, it is rumored that even in Soviet Russia, under the five-year plan, there are varying prices for those who wish to sleep en route as contrasted with those who seek to torture themselves through the night on the hard seats of the coaches.

### **Experiments in Medical Practice**

In response to the demand for the finer refinements of medical science applied to the ten per cent. of serious diseases that has been mentioned, the hospitals, the X-ray departments, and the clinical laboratories began to function. Then came some of the experiments already in effect for distributing the cost of these refinements over a considerable number of patients, and thereby lowering the expense to the individual. These experiments have involved the development of groups such as the Mayo Clinic, and several hundred replicas thereof on a smaller scale, throughout the country. The desire to utilize such refinements caused the organization of commercial clinical laboratories, which provide laboratory service at fixed fees, sometimes the laboratories being the property of physicians and, in other instances, owned by business men who employ physicians to carry out the work. The American Medical Association has wisely refused to recognize on its approved list any laboratory not under the direction of a reputable physician.

Coincidental with the advancement in medical science came the expansion of the curriculum of the medical school, the raising of requirements for admission, and the demand for hospital internship subsequent to medical education. With these requirements it became impossible to conduct a medical school as a profit-making venture or without endowment. Increasingly medical educators went to the state or to great philanthropies in search of funds to meet the deficits. Since a sufficient number of beds for teaching purposes is essential to a well-conducted medical school, hospitals were built as portions of medical schools. These hospitals were conducted at first as part of the service to the poor, which medicine has ever rendered uncomplainingly and without payment.

As has been shown, the increased cost of medical care began to be reflected in the daily cost of hospital beds. This cost increased gradually from \$1.25 daily per bed until it reached a figure as high as \$11 to \$12 daily per bed in some institutions. There are few medical institutions with sufficient endowment to meet such burdens. Soon institutions began to cast about for means of supplementing the endowment. Then arose as a part of the educational scheme, but incidentally as an attempt to answer the problem of the cost of medical care for the middle class, the conception that full-time teachers in the clinical department of university medical schools might earn funds for the school through the fees paid by patients, these sums to be applied to the conduct of the hospital. Thus, available information indicates one full-time professor of surgery in a Class A medical college who receives a salary of \$18,000 a year and earns \$125,000 a year for the institution that employs him.

In the meantime, it is well to recall, American communities have been supporting many forms of organized medical practice which have long been recognized by competent observers to be unsatisfactory, inadequate, uneconomic makeshifts. Lodge practice is the curse of small communities consisting largely of people of foreign parentage. Mutual benefit schemes have been sold by fly-by-night promoters to American wage earners. Organized clinics have entered into contractual arrangements with labor unions or unorganized groups of workers to provide a type of medical service that is by no means a sufficient service. Insurance companies sell health insurance policies for high premiums, which are required because an exceedingly small minority of the population purchase such policies. Moreover, all of the power rests with the company, and both patient and physician must in many instances resort to the courts to benefit by the policy. Finally, many industrial corporations, department stores, banks, and similar businesses have evolved schemes of medical care for employees and also in some instances for the employee's family.

### **Preventive Medicine**

And then there are the health departments! From the beginning, medicine has been an individualistic profession. With the coming of the great plagues in the fourteenth and fifteenth centuries, man began to organize against disease. The first great public health council was held in the Middle Ages to take measures against the plague. With the establishment of modern knowledge of infectious diseases, it is recognized that there are some forms of prevention of disease in which the state or municipality can do more for the individual than he can do for himself. Typhoid, for instance, is largely controlled by the community as a whole. Its control depends on pure water supply, proper disposal of sewage, clean food, and the isolation of the typhoid carrier. No doubt, the application of community sanitation and hygiene to the prevention of infant mortality, the elimination of smallpox, and the control of typhoid and the acute infectious diseases has been largely responsible for the increased longevity of which we proudly boast. However, it remains to be established that heart disease, diabetes, cancer, and other degenerative disorders, which constitute the chief causes of death in the present decade, are to be controlled by any procedure applied to the community as a whole. The recognition, the prevention, and the treatment of these disorders is distinctly a problem affecting the individual, in which only another individual can function satisfactorily as a diagnostician and therapist. It remains to be established that any organization or corporation can undertake periodic physical examination to better advantage than can the family physician. The disorders of middle life demand individualization above everything else. The physician who knows the patient, his family history, his business career, and

the social and mental aspects of the patient's life, is best fitted to advise him concerning prophylaxis against decay.

Here, then, is the current scene—a sketchy map of the present status of medical practice. The system reveals most medical care in the hands of general practitioners and specialists working in a vast number of hospitals. By this means the majority of our people are receiving medical care that must be of considerable adequacy because certainly our morbidity and our mortality rates compare favorably with those of other civilized countries, with or without systems of compulsory health insurance or state medicine.

Nevertheless it would be folly to claim that the best type of medical care is available to all the people for a price that they can afford to pay, and that seems to be the ideal that is sought. Health departments are greatly concerned with preventive medicine, and the majority of private practitioners, especially the specialists, but slightly. Hence there proceed innumerable experiments in changing the nature of medical practice and, from many social leaders, cries for a revolution.

### **Evolution and Revolution**

It is, of course, reasonable to believe that our methods of medical practice will change to accord with changing times. We are concerned with retaining all that is good from the past and with preventing mistakes in the future. It is important that the change in medical practice come by evolution rather than by revolution. Never was there a revolution which did not swing too far and, like the pendulum, be forced to swing beyond the mid-line before arriving finally at the logical center.

The prophets who endeavor to predict the nature of medical practice for the future divide themselves into two groups. On one hand are those who feel that the individualistic practice of medicine, as it has existed in the past, must be supplemented by forms of organized medicine which will offer modern scientific medical care on terms that make it economically and psychologically easy of attainment. On the other hand are those who feel that, for the good of both the public and the practice of medicine, there should be no further evidence of governmental control or interference in the field of health and of medicine until sufficient study has been given to assure the retainment in medical practice, under any new plan, of those factors which have brought modern scientific medicine to its present estate.

### **Controlled Experiments**

It has been well emphasized that the medical profession has led in the field of research in science, but that it is among the most conservative of groups when considering possible experimentation in the fields of social organization. Scientific physicians demand laboratory study for confirmation of the value of any remedy before applying that remedy to their patients. They demand suitable controls before they are willing to accept evidence. They feel, no doubt, that the criteria which apply to the judgment of a scientific experiment should be used in evaluating experiments in social fields. They are unwilling to accept the word of the promoter of a demonstration that the demonstration has been an unqualified success. They are inclined to wait until the subjects of the demonstration, *namely*, the physician and the people of the community submit their evidence in the matter. They are unwilling to accept the unsupported statement of the economist that the best medical care must be given to all the people at a price that they can afford to pay, until the economist can show that such care can be provided at a price that people can afford to pay, and until the economist can work out systems



for controlling the supplies of food, fuel, clothing, and suitable homes for these same people. Already the social workers have taught us that disease is not always caused by germs—that sometimes housing and food play vital parts in its prevention.

The medical profession has been averse to experiments which do not seem to have been properly organized or directed, and which do not take into account correctly the medical factors that are significant. Far too often, experiments in changing the nature of medical practice have been conceived, outlined, and put into effect by lay directors without suitable medical advice. Such experiments not infrequently lead to the degradation of the profession of medicine. Evidence is available to indicate that several such experiments have succeeded financially only because they exploited both the patient and the physician who were concerned. It is not surprising that any self-respecting profession should refuse to become party to such plans. As essential factors in experiments in medical practice, physicians must be permitted a voice in determining the conditions of the experiment, and the final voice in determining the medical conditions.

#### Experiments Abroad

Whatever the public wants and is willing to pay for, it gets. There does not seem as yet to have been developed in any country a complete system of medical care that can be called satisfactory. Of the countries where there is compulsory sickness insurance, free choice of physician exists only in Great Britain, France, Luxembourg, Bulgaria, and Chile. In their recent report Drs. Simons and Sinai point out that the number of claims and the lengths of illness have invariably increased wherever sickness insurance has been established. Whenever payment for the cost of disease is associated with the dole or with payment for unemployment, the number of abuses multiplies alarmingly. Sickness benefit may be a poor substitute for wages, but among low-paid workers, among domestics, and in periods of great unemployment, it becomes at least some sort of substitute for lack of funds.

Even the Russians have not been so foolhardy as to endeavor to eliminate the personal factor in medical practice. "There have been many suggestions for the suppression of private practice," writes Grossman of Smolensk, "but the National Public Health Commission has taken no direct action. The psychologic factor in sickness demands the better qualified and specialized physician and he is in private practice."

And another Russian physician, I. M. Gubinskiy, writes:

Medicine has been calling for additional trained personnel. Since state and coöperative medicine have not been able to cover the whole territory, private practice has had to do the rest. The increased demand for medical aid is due first to increase in education and, second, in spite of a decrease in mortality, to an increase in disease. Third, there has been an increase in simulated illness encouraged by socialized insurance. The increase in the number seeking medical aid has resulted in overcrowded dispensaries and long waiting lines as well as decreased medical attention for each patient examined. When on examination the patient is diagnosed for treatment, he has no other alternative than the community dispensary for which he obtains a written excuse from work, but if no such excuse is given, the patient has to go to a private clinic or to the home of a private practitioner. It is evident that improvement in state medical aid is necessary, but higher standards can not be attained in several but possibly in ten or more years. I believe that present private practice in the form of offices or collective clinics has its *raison d'être*. The private physician does not earn more than a state physician; but the patient is given, instead of seven to eight minutes, fifteen or twenty to thirty minutes of the private physician's time. Then there is the problem of the dual character of some state physicians, who are also engaged in private practice at home. But since the number of doctors is small, this has become a necessity. To discourage private practice by state physicians, it is suggested that the number of physicians should be increased, and this can be

accomplished by increase in state salaries and also boycotting of those engaged in private practice. At any rate it is suggested that the young group of physicians should be discouraged from private practice and in time stricter and stricter measures taken against private practice.

### **The Experiments with the Curriculum**

There has been a constant struggle to fit the curriculum of the medical school to the changing medical needs of the nation. The suggestion has been made that two types of physicians be trained—short-term doctors for country cases and long-term doctors for serious illnesses. Such a panacea is so obviously ridiculous as to require but a moment's consideration. Already there are among us such short-term healers of sickness as the osteopaths, the naturopaths, and the chiropractors. Once in the practice of healing, they do not limit themselves to any variety of disease. Moreover, they concentrate in the cities and seek the wealthiest clientele, by no means offering for the wage earner a substitute for a physician nor for the farmer a doctor of easy access. Actually the patient remote from a hospital or the possibility of consultation demands the highest type of physician that modern medical education can develop.

The suggestion has been made that little or no attention be given to the specialties in the schools, but that they confine themselves to the training of general practitioners, leaving to those who wish to specialize opportunity for graduate education in graduate schools or as assistants. The general practitioner must, however, be a specialist in every field. He never knows the moment when he may be called on to perform the most difficult of surgical operations or to diagnose the most insidious disease. Furthermore, as long as the rewards of specialization are so superior to those of general practice, the specialties are worth working for.

Few people realize that modern medical care, even at the hands of general practitioners, demands the vast armamentarium that it requires or calls into practice such a tremendous number of assistants and technicians. Labor costs are invariably the highest costs in any professional field. It has not yet been shown that it is possible to give competent medical care in the ten per cent. of difficult cases without expert laboratory, X-ray, dietetic, and similar advice.

The principles that have produced some fifty per cent. of specialists in a profession in which eighty-five per cent. of the work to be done could be done by general practitioners are, no doubt, the same principles that apply in every other human occupation. The rewards of the specialist, the hours of work, the interest of his occupation, are such as to make for specialization an appeal greater than that of general practice. When the rewards of the general practitioner and the interest of his work become such that general practice can compete as an attraction with the specialties, more physicians, being human beings, will become general practitioners.

### **The General Practitioner and Preventive Medicine**

It has become apparent that the general practitioner of the future will depend largely for his existence on the practice of preventive medicine as well as on the treatment of disease. Strangely there has developed—no doubt largely by the effects of demonstrations, the actions of public health authorities, and the preachings of social workers—the idea that only curative medicine is to be paid for; that preventive medicine is the duty of the state; and that it is a function which the state will assume. There are two types of preventive medicine; *first*, that for which the community is primarily responsible and which only the community can perform; *second*, that which

involves action of one individual on another and which should always be a function of private practice. Significant in this connection is an incident reported as a part of a recent demonstration for the control of diphtheria. An enlightened health officer persuaded his community by the use of posters in street cars and on buses, by lectures over the radio, by announcements in the newspapers, and even by circulars sent directly to homes that the administration of toxin-antitoxin or of toxoid to children is a most important step in the control of diphtheria. This health officer realized, of course, the danger of interfering with the confidence of patients in their family physicians, so his suggestion concluded: "Ask your physician, or come to the health department."

Following is a typical conversation that ensued between a mother and the family doctor:

"Doctor, do you believe in giving of toxoid to prevent diphtheria?"

"Yes, indeed."

"Do you use the same serum that the health department uses?"

"Yes, indeed."

"What do you charge, doctor?"

"Five dollars."

"Doctor, does the health department give the same treatment that you give?"

"Yes."

"Do they charge anything?"

"No. They take the funds out of the taxes."

"Well, doctor, wouldn't I be a simpleton to pay you \$5 when I can get the same service from the health department for nothing?"

And being an honest doctor, he encouraged her to get the service from the health department because he recognized the importance of the preventive procedure. The physician in private practice can not compete in the field of preventive medicine with state-owned and tax-paid-for services of this character.

### **The Physician in Industry**

If every steel mill, department store, and similar industry employs salaried physicians to provide medical service to employees, three-fourths of the people in this country who earn money will be removed as a possible source of income from private practitioners. Then, by the laws of nature, practitioners will no doubt disappear.

There would seem to be no reason why any great industry that wishes to safeguard the health of its employees should not provide physicians to be consulted by these employees in emergencies, to advise them regarding the prevention of disease, and, *if necessary*, even to give them medical care. But industrial physicians should not compete unfairly with other physicians in the community; they should not employ methods for the promotion of their practices beyond the methods available to other physicians. They should not, for a bare living salary, endeavor to treat employees and their families, because they cannot do justice to their patients and thereby they degrade the profession that they serve.

### **University Practice**

It is reasonable to believe that universities and medicine schools will continue to conduct hospitals in which patients will be treated for pay. It is not conceivable that such institutions will be able to finance their hospitals without fees from patients. In conducting hospitals, however, universities should limit, as far as possible, competition on an unfair basis with the men that it educates and places in the community. These graduates have a right to fairness. The size and expansion of a university clinic should be limited

to the number of beds necessary for teaching purposes. The fees established by the university, when it takes care of the wealthy, should not be markedly less than the usual fees in the community. It seems doubtful, although I believe Mr. Michael Davis has expressed the hope, that great expansion of university clinics will in any measure answer the cry for suitable care of the great middle class and the wage earner. The function of the university and the medical school should be teaching and research, not the practice of medicine.

### **The Trend of Private Practice**

Our present social organization is complicated. It varies greatly from city to city, from village to village, from state to state; it varies tremendously from person to person, from industry to industry. It is inconceivable that any single plan will be developed for a system of medical practice applicable to every inhabitant of our country. The problem of providing funds for medical care is, after all, not a medical problem; it is a problem for bankers, economists, and statesmen. Insurance is a means of saving for an emergency, for the replacement of lost property and lives. Insurance may be compulsory or voluntary. The American people should never consent to compulsory health insurance—but in some of our states they may. Then the remaining states will be able to watch the experiment. True, there are available excellent reports of the experiments abroad. The books by Simons and Sinai, and by Newsholme, and the report of Rappleye for the Commission on Medical Education have shown that thus far not one system has attained complete satisfaction. Conceivably a system might be devised that will provide free choice of physician, insure adequate practice of preventive medicine, place responsibility on the patient for maintaining the insurance and on the physician to the patient, stimulate initiative and research among physicians who participate, and be free from political manipulation, graft, and other weaknesses usually associated with state control. But, alas, such a system has not appeared abroad, and the history of American statesmanship and government control in other fields does not indicate its likelihood among us.

### **Health Education**

There remains the necessity of teaching the people the importance of saving for sickness as they now save in anticipation of postponed pleasure or death. Great insurance companies spend immense sums on education of their policyholders with a view to causing those policyholders to live longer and thereby to postpone the date of final payment on their life insurance. With the establishment of health insurance abroad, the amount of money spent on medical care increased from three to five times. The reports of the Committee on the Costs of Medical Care indicate that we shall have to spend much larger sums than are now spent to give to all our people the best type of medical care. It has been shown that advance in medical science has made modern diagnosis and treatment in the ten per cent. of serious disease exceedingly costly. We have the physicians and the equipment to provide the best, but apparently the people do not have or will not save the money to pay for it.

An extensive campaign of education in newspapers, in magazines, directly by mail, through lectures and over the radio in behalf of voluntary sickness insurance might result in causing a sufficient number of people to apply for such insurance if it can be offered at a price that could be met by the wage earner. Simons and Sinai consider any voluntary system merely a short bridge to a compulsory plan.

People know that death is inevitable. In teaching preventive medicine, we have emphasized that sickness may be prevented. To-day we know that



some sickness for every family is just as inevitable as death, and unless obstetrics continue to be inevitable there will be no population for the future. Let us, therefore, teach the worker that 2,000,000 people are sick every day in 120,000,000 population, and that this number is not likely to change greatly in the future, even with considerable advance in the application of preventive medicine. Even should disease itself be largely outlawed from the human race, degeneracy and decay and ultimately death must be the lot of all of us. Associated with death and decay come inevitable illnesses that must be provided for; the need for the physician and for curative medicine will never disappear.

### Summary

To recapitulate, great progress in medical science has substituted for the family physician a complex system including hospitals, laboratories, technicians, dietitians, nurses, and a greatly increased equipment and personnel.

The family physician will always be the most economic and practically the most satisfactory physician for ninety per cent. of human ailments.

The remaining ten per cent. of human ailments require hospitalization and specialization.

Modification of the curriculum or abbreviation will not lead to a greater number of general practitioners. The rewards of general practice must be made attractive in comparison with the rewards of specialization.

The general practitioner must become increasingly a practitioner of preventive medicine, and people must learn that preventive medicine is, like curative medicine, to be paid for, particularly because it is always worth more than it costs.

Organized medical practice in the form of groups, university clinics, industrial medicine, insurance practice, and contract practice may have definite fields in medical practice. For the good of the public and for the advancement of medical science, they should limit themselves to the fields for which they are fitted.

People must learn to save for sickness as they now save for luxuries or in anticipation of death.

If the people can not be educated to saving for sickness, voluntary health insurance or even compulsory health insurance will probably come.

The physician in private practice will not disappear. Under every compulsory health insurance system, and even in Soviet Russia, he persists because only a personal physician can function efficiently in a vast number of types and cases of disease.

Until human bodies and minds are standardized—an antibiologic conception—individual mutual responsibilities between patient and physician must be maintained.

—from *The Diplomat*.

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No antiricketic substance will straighten bones that have become misshapen as the result of rickets. But Mead's Viosterol in Oil 250 D can be depended upon to prevent ricketic deformities. This is not true of all antiricketic agents, many of which are so limited by tolerance or bulk that they cannot be given in quantities sufficient to arrest the ricketic process promptly, with the result that the bones are not adequately calcified to bear weight or muscle-pull and hence become deformed.

## Country Doctor

By *Edith Tatum*

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HE calls no hour of day or night his own.  
Through heat or cold he goes his rounds alone;  
Here, to bring some mortal into being,  
There, to ease some soul that must be fleeing.  
He listens earnestly to tales of grief,  
Forgets himself that he may give relief  
To bodies suffering, or tortured minds;  
In service to all men his pleasure finds.  
May God forever bless him with His grace,  
For when he goes, oh, who will take his place?



# Clinical Meetings

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**At Brandon General Hospital—**

2nd Wednesday at 12.30 p.m.

**At Brandon Hospital for Mental Diseases—**

Last Thursday. Supper at 6.30 p.m.

Clinical Session at 7.30 p.m.

**At Children's Hospital—**

1st Wednesday.

Luncheon at 12.30 noon.

Ward Rounds 11.30 a.m. each Thursday.

**At Misericordia Hospital—**

2nd Tuesday at 12.30 p.m.

**At St. Boniface Hospital—**

2nd and 4th Thursdays.

Luncheon at 12.30. Meeting at 1.00 p.m.

Ward Rounds 11.00 a.m. each Tuesday.

**At St. Joseph's Hospital—**

4th Tuesday.

Luncheon at 12.30. Clinical Session 1.00 to 2.00 p.m.

**At Victoria Hospital—**

4th Friday.

Luncheon at 12.00. Meeting at 1.00 p.m.

**At Winnipeg General Hospital—**

1st and 3rd Thursdays.

Luncheon at 12.30. Clinical Session 1.00 to 2.00 p.m.

Ward Rounds 10.00 a.m. each Thursday.

Pathological Conference at Medical College at 9.00 a.m.

Saturday during college term.

**Winnipeg Medical Society—**

3rd Friday, Medical College, at 8.15 p.m.

Session: September to May.

**Eye, Ear, Nose and Throat Section—**

1st Monday at 8.15 p.m., at 101 Medical Arts Building.



"If one wishes to fortify cod liver oil, it is far more reasonable and efficacious to increase its potency by adding a small amount of viosterol, which is a specific in the prevention and cure of rickets, as it brings about calcification not only of the bone but of the proliferating cartilage as well." (Hess, Alfred F., Am. J. Dis. Child. 41:1081; May, 1931.)

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Mead's 10 D Cod Liver Oil is the only brand that combines *all* of the following features:

1. Council-accepted. 2. Made of Newfoundland oil (reported by Profs. Drummond and Hilditch to be higher in vitamins A and D than Norwegian, Scottish and Icelandic oils). 3. Supplied in brown bottles and light-proof cartons (these authorities have also demonstrated that vitamin A deteriorates rapidly when stored in white bottles).

In addition, Mead's 10 D Cod Liver Oil is ethically marketed without public advertising or dosage directions or clinical information. With Mead's,—*you* control the progress of the case.

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*Mead's 10 D Cod Liver Oil is therefore worthy of your personal and unfailing specification. This product is supplied in 3-oz. and 16-oz. brown bottles and light-proof cartons. The patient appreciates the economy of the large size.*

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